



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BONNIE LAMMERS, MD
PO BOX 121589
ARLINGTON TX 76012

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-1400-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These services were requested and prescribed by the Division. The above referenced designated doctor performed the MMI examination and assigned the IR, but he [sic] did not perform the range of motion, strength, or sensory testing of the musculoskeletal body area(s), that means he should bill using the appropriate MMI CPT code 99456 with the component modifier -26. Reimbursement for the examining doctor is 80% of the MAR. The physical therapist and/or health care provider other than the examining doctor that performs the range of motion, strength, or sensory testing of the musculoskeletal body, the physical therapist and/or health care provider is 20% of the MAR. The bills from the two parties must be coordinated and billed appropriately and should be billed at the same time for the correct reimbursement."

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Message modifier code 732 indicated that the CPT code and/or modifier billed by the requestor was incorrect. The requestor's report indicates the claimant had not reached MMI. Subsection (j)(2)(A) of Rule 134.204 states, '...If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.' As one can see, the requestor did not bill in that manner."

Response Submitted by: TEXAS MUTUAL INSURANCE CO, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 21, 2009	99456-W5-26 and 99456-W5-TC	\$650.00	\$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 22, 2010

- CAC-4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
- 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT AND/OR MODIFIER BILLED INCORRECTLY. SERVICES ARE NOT REIMBURSABLE AS BILLED.

Explanation of benefits dated November 22, 2010

- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- CAC-4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
- 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT AND/OR MODIFIER BILLED INCORRECTLY. SERVICES ARE NOT REIMBURSABLE AS BILLED.

Issues

1. Did the requestor submit documentation to support the disputed services were coded properly in accordance with Texas Administrative Code, Section §134.204?
2. Is the requestor entitled to reimbursement in this dispute?

Findings

1. The services rendered were billed in accordance with 28 Texas Administrative Code §134.204. The professional services were billed and technical range of motion (ROM) was also billed. Review of the submitted documentation finds that the Designated Doctor (DD) narrative shows Maximum Medical Improvement (MMI) date as May 24th, 2010. It also shows a Whole Person Impairment Rating (IR) determination of zero (0) percent. The respondent position statement asserting that the billing should have an –NM on the billing does not reflect the narrative which shows an IR was rendered, not a “no impairment” determination. Therefore, these payment denial reasons are not supported. CPT codes 99456-W5-TC and 99456-W5-26 are payable per the methodology found in 28 Texas Administrative Code §134.204. The rule shows that 80 percent of total MAR for MMI/IR is payable for the professional charges of the examining doctor billed with -26 modifier and 20 percent of total MAR for MMI/IR is payable for the technical component services billed with –TC modifier.
2. Review of the submitted documentation finds that MMI was assigned which has a MAR of \$350.00. The narrative also shows that ROM was performed. Documentation shows that ROM was performed but that the only calculation used for the IR was a Diagnosis Related Estimates (DRE) rating based on the non-musculoskeletal right upper arm skin laceration. As ROM is not utilized in this case for the IR and DRE methodology is used instead, the MAR is \$150.00 per 28 Texas Administrative Code §134.204. The total MAR is \$500.00 for combined MMI and IR calculation.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 04, 2011
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.